

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/22/2013	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 18, 19, 20, 21, 22, 2013</p> <p>Facility number: 000459 Provider number: 155567 AIM number: 100289700</p> <p>Survey team: Tim Long, RN, TC Rick Blain, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF: 2 SNF/NF: 69 Total: 71</p> <p>Census Payor type: Medicare: 10 Medicaid: 46 Other: 15 Total: 71</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 26, 2013 by Randy Fry RN.</p>		F0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of a recommendation by the Registered Dietitian to start a</p>		F0157	<p>It is the policy of this facility to notify the M.D. of any written recommendations by the Registered Dietician. I. There was no negative outcome for the resident. The resident desired to</p>		03/22/2013	

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	<p>nutritional supplement to address weight loss for 1 of 35 sampled residents reviewed for physician notification (Resident #23).</p> <p>Findings include:</p> <p>The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON further indicated if a resident was receiving a nutritional supplement, the administration of the supplement would be indicated on the Medication Administration Record (MAR).</p> <p>A print out of weights for Resident #23, provided by the facility Medical Records Director on 2/20/2013 at 3:10 P.M., indicated the resident had weighed 143.2 pounds on 11/21/2012 and had weighed 131.00 pounds on 02/06/2013, indicating an 8.5% weight loss in 77 days.</p> <p>A note by the Registered Dietitian (RD), dated 2/6/13, indicated "RD</p>			<p>lose wt.II. No other residents were affectes, or identified.Aduits were done on all recent quarterly resident assessments to ensure that any dietary recommendations were completed.See attachments #3 a,b,c)III. The Registered Dietician will implement the approved Covenant Care recommendation forms, (see attachment # 1) to ensure that the recommendations are reviewed timely. A review and re-education of the procedure of recommendation, completed with RD. and Dietary Manager.(See attachment II)A. The RD will exit with the DON or Designee and review her recommendations with a verbal and written recommendation report.B. A audit tool will be implemented to track all RD recommendations weekly. (see attachment # 2+3) DON or Designee will monitor and audit the RD's list weekly to ensure compliance. IV. The weekly audit tools will be brought to the monthly QMP meetings for compliance review by the committee, for 6 mos.V. Date completed 3/22/2013</p>			

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	<p>review. Resident 2/4/13 wt (weight): 132 lbs which represents a 2% wt loss in 30 days & an 8% wt loss in 90 days & a 4% wt loss at 180 days" The note also indicated "Will recommend health shake (nutritional supplement) once daily to (increase) daily Kcal (kilocalorie)/pro (protein) intakes."</p> <p>The MAR for February 2013 for Resident #23 did not indicate the resident had begun receiving health shakes after 2/6/2013 as recommended by the RD.</p> <p>A review of current physician orders for Resident #23 indicated an order for "Healthy Shake" had been entered into the facility's computer system on 2/6/2013, but the order was still indicated as "pending" as of 2/21/2013.</p> <p>The facility ADON was interviewed on 2/21/2013 at 9:50 A.M. The ADON indicated the order for the health shake was still indicated as "pending" in the computer because the physician had not yet signed the order and the order had not yet been implemented. The ADON indicated the RD had apparently entered the recommendation to start the health shakes for Resident #23 into the</p>						

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	<p>computer on 2/6/2013 and the recommendation had appeared in the computer system as a pending order. The ADON indicated the RD had not informed the nursing staff of the recommendation. The ADON indicated the nursing staff would have notified the physician if they had been aware of the recommendation and they would have documented the notification in the Nursing Notes. The ADON indicated the physician would have then signed the order electronically and the order would have then been indicated as having been signed. The ADON indicated the order would have then been entered onto the resident's MAR and the resident would have started receiving the health shakes. The ADON was unable to provide any documentation in the record to indicate the physician had been notified of the recommendation, or had approved of and signed the order. The ADON indicated the health shakes for Resident #23 were not on the MAR for February 2013 and the shakes had not yet been started.</p> <p>The facility Director of Nursing (DON) was interviewed on 2/21/2013 at 10:15 A.M. During the interview, the DON indicated the physician was not notified of the recommendation for</p>						

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	the health shake until 2/21/12 and he had denied the order for the health shake and instead, had ordered Glucerna (a nutritional supplement) for the resident. 3.1-5(a)(3)						

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to implement a recommendation by the Registered Dietitian to start a nutritional supplement to address weight loss for 1 of 3 residents reviewed for nutrition in a sample of 5 residents who met the criteria for nutrition (Resident #23).</p> <p>Findings include:</p> <p>The record for Resident #23 was reviewed on 2/20/12 at 10:00 A.M. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 2/18/2013 at 2:00 P.M. During the interview, the ADON indicated Resident #23 was not receiving any nutritional supplements. The ADON further indicated if a resident was</p>		F0325	<p>It is the policy of this facility to review all Registered Dietician recommendations, with the attending M.D. for implementation. There was no negative outcome for the resident, the resident desired to lose wt. II. No other residents were affected or identified. Audits were done on all recent quarterly resident assessments to ensure that dietary recommendations were completed. (See attachments # 3 a,b,c) III. The Registered Dietician will implement the approved Covenant Care recommendation from, (see attachment # 1) to ensure that recommendations are reviewed timely. A review and re-education of the procedure of recommendation completed with RD and Dietary Manager. (See attachment II) A. The RD will exit with the DON or Designee and review her recommendations with a verbal and written recommendation report. (see Attachment # 2). B. An audit tool</p>		03/22/2013	

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	<p>receiving a nutritional supplement, the administration of the supplement would be indicated on the Medication Administration Record (MAR).</p> <p>A print out of weights for Resident #23, provided by the facility Medical Records Director on 2/20/2013 at 3:10 P.M., indicated the resident had weighed 143.2 pounds on 11/21/2012 and had weighed 131.00 pounds on 02/06/2013, indicating an 8.5% weight loss in 77 days.</p> <p>A note by the Registered Dietitian (RD), dated 2/6/13, indicated "RD review. Resident 2/4/13 wt (weight): 132 lbs which represents a 2% wt loss in 30 days & an 8% wt loss in 90 days & a 4% wt loss at 180 days" The note also indicated "Will recommend health shake (nutritional supplement) once daily to (increase) daily Kcal (kilocalorie)/pro (protein) intakes."</p> <p>The MAR for February 2013 for Resident #23 did not indicate the resident had begun receiving health shakes after 2/6/2013 as recommended by the RD.</p> <p>A review of current physician orders for Resident #23 indicated an order for Healthy Shake had been entered</p>			<p>will be implemented to track all RD recommendations weekly. (see attachment # 2&3) DON or Designee will monitor and audit the RD's list weekly to ensure compliance.IV. The audit tools will be brought to the monthly QMP meetings for compliance review by the committee for 6 mos.V. Date completed: 3/22/2013</p>			

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	<p>into the facility's computer system on 2/6/2013, but the order was still indicated as "pending" as of 2/21/2013.</p> <p>The facility ADON was interviewed on 2/21/2013 at 9:50 A.M. The ADON indicated the order for the health shake was still indicated as "pending" in the computer because the physician had not yet signed the order and the order had not yet been implemented. The ADON indicated the RD had apparently entered the recommendation to start the health shakes for Resident #23 into the computer on 2/6/2013 and the recommendation had appeared in the computer system as a pending order. The ADON indicated the RD had not informed the nursing staff of the recommendation. The ADON indicated the nursing staff would have notified the physician if they had been aware of the recommendation and they would have documented the notification in the Nursing Notes. The ADON indicated the physician would have signed the order electronically and the order would have then been indicated as having been signed. The ADON indicated the order would have then been entered onto the resident's MAR and the resident would have started receiving the health shakes.</p>						

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	<p>The ADON was unable to provide any documentation in the record to indicate the physician had been notified of the recommendation, or had approved of, and signed the order. The ADON indicated the health shakes for Resident #23 were not on the MAR for February 2013 and the shakes had not yet been started.</p> <p>The facility Director of Nursing (DON) was interviewed on 2/21/2013 at 10:15 A.M. During the interview, the DON indicated she had spoken with the RD by telephone and the RD had indicated she thought when she entered a recommendation into the facility's computer system, the recommendation would automatically be entered onto the resident's MAR. The DON indicated the RD had not informed nursing staff of the recommendation for the health shake. The DON indicated the physician was not notified of the recommendation for the health shake until 2/21/12 and he had denied the order for the health shake and instead had ordered Glucerna (a nutritional supplement) for the resident.</p> <p>3.1-46(a)(1)</p>						

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F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the nursing staffing hours for licensed and unlicensed staff was posted on a daily basis.</p>	F0356	<p>It is the policy of this facility that staffing will be posted seven days a week.I. No residents were affected. II. All residents could have the potential to be affected.III.1. Re-education of week-end Supervisor and the</p>		03/10/2013		

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	<p>Findings include:</p> <p>During the initial tour of the facility, at 9:30 a.m., on 2/18/13, the nursing staffing hours were posted at the front reception desk, but were dated 2/13/13.</p> <p>The Administrator was interviewed, at 9:10 a.m., on 2/20/13 and indicated CNA # 8 was responsible for posting the nurse staffing schedule.</p> <p>CNA #8 was interviewed, at 9:12 a.m., on 2/20/13, and indicated she was the scheduler. She indicated she normally posted the nursing staffing hours daily, but did not work weekends and no one was assigned to post the schedule on the weekends.</p>				<p>scheduler on the procedure for posting staffing , 3-5-13.(see attachments 4+5) 2.MOD will check to ensure,current staffings are posted in a prominent location. 3. Copies of weekend staffing sheets will be kept in a Binder in Don office. In order to validate that staffing was posted, on weekly basis by the DON or Designee. IV. Staffing binder will be brought to QMP by the DON or Designee for review by the committee for 6 months.V. Completion March 22, 2013</p>		

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure a recommendation for a Gradual Dose Reduction was acted upon by the physician, for 1 resident in a sample of 10 residents reviewed for Unnecessary Medications, Resident #15.</p> <p>Findings include:</p> <p>The clinical record for Resident #15 was reviewed, at 2:00 p.m., on 2/21/13. Diagnoses included, but were not limited to, senile dementia with delusions, depression, and anxiety.</p> <p>Current Physician orders, electronically signed by the physician and dated 12/12/12, indicated the resident was receiving Abilify (an antipsychotic medication) 15 milligrams, by mouth, daily, and Sertraline (Zoloft), a medication used for depression, 100 mg. daily.</p>		F0428	<p>It is the policy of this facility to GDR on residents who are on Psychotropic medications every Quarter or as needed. I. No negative outcome to resident.II. No other residents were affected.Residents who have had a quarterly MDS due in the last Quarter were audited by the SSD and Pharmacy consultant to ensure compliance. (See attachment #9&9a)III.Behavior Management will be done by Pharmacy Consultant, SSD, Don or Designee monthly.Recommendations will be reviewed at exit conference with Pharmacy Consultant and Don or Designee.SSD will review recommendation with MD. for approval or denial of the orders. SSD will give the MD orders to Nurse Unit managers for follow up and processing. (See attachment # 10)IV. Audit Tool was implemented for SSD to ensure that all MD orders for GDR's are completed within 72hours. (See attachment #9 & 9a) This tool will be done on a monthly basis by the Social</p>		03/10/2013	

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	<p>The Director of Nursing was interviewed, at 10:30 a.m., on 2/22/13, and indicated these were current physician orders, and were supposed to be signed monthly by the physician, but the physician had not electronically signed the orders since 12/12/12.</p> <p>Review of an Interdisciplinary Psychopharmacological Review form, dated 4/11/12, indicated the resident was taking Abilify 15 milligrams daily for delusions and Zoloft 100 milligrams daily for depression. The Interdisciplinary Team (IDT) indicated the resident continued to have episodes of agitation and delusions, but was not due for reduction of medications at this time.</p> <p>A review date of 10/4/12, on the same form, indicated the resident's mood and behavior were stable and the IDT would refer to the physician for evaluation of the Abilify.</p> <p>A review date of 1/3/13, on the same form, indicated the resident was stable at this time and the IDT would refer to the physician for evaluation for a gradual dose reduction (GDR) of the Abilify.</p> <p>The Social Service Director was interviewed at 2:10 p.m., on 2/21/13,</p>			Service Director, to ensure compliance, V. Audit tools will be brought to QMP for committee review for 6 months. Completion by March 22, 2013.			

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	<p>and indicated after the Behavior Management Committee met, with the pharmacist in attendance, a consultation report from the Behavior Management Committee for a gradual dose reduction of the medication would be sent to the physician for review and recommendations. She indicated the recommendation for the gradual dose reduction of Abilify was sent to the physician, but she could not find documentation the forms were received back from the physician. She indicated the physician was supposed to return the form to the facility with his recommendations within 72 hours. The Social Service Director indicated once the consultation form was received, the unit managers were supposed to assure the physician orders were acted upon and written. The Social Service Director indicated she also was supposed to receive a signed copy of the Consultation form the physician signed. She indicated if the form was not returned to the facility within 72 hours with recommendations, the physician would be called. She indicated she could not find documentation this had been done.</p> <p>At 2:50 p.m., on 2/21/13, the Director</p>						

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	<p>of Nursing Services (DNS) provided 2 Consultation Reports addressed to the resident's physician regarding gradual dose reduction of the medications.</p> <p>Review of the first Consultation Report, at 3:00 p.m., on 2/21/13, and dated 10/4/12, indicated the Behavior Management Committee had sent a recommendation to the physician. The form indicated the resident was currently receiving Abilify 15 milligrams daily and Zoloft 100 mg daily. The recommendation indicated, "please consider a gradual dose reduction, perhaps decreasing Abilify to 10 mg. daily while concurrently monitoring for re-emergence of target and /or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction of Zoloft as clinically contraindicated. "</p> <p>This form was not signed by the physician, nor were any recommendations made by the physician.</p> <p>Review of the second Consultation Report, dated 1/3/13, indicated the resident was receiving Abilify 15 mg. daily and Zoloft 100 mg. daily. The recommendation indicated, "Please consider a gradual dose</p>						

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	<p>reduction, perhaps decreasing Abilify to 10 mg. daily while concurrently monitoring for re-emergence of target and /or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction of Zoloft as clinically contraindicated. "</p> <p>This form was not completed or signed by the physician.</p> <p>The Director of Nursing Services (DNS) was interviewed at 9:38 a.m., on 2/22/13, and indicated the facility did not have a policy for Gradual Dose Reduction(GDR) of Medications, but she provided a "Procedure for GDR" at 9:38 a.m., on 2/22/13, which she indicated she had documented for the procedure the facility followed for GDR. The procedure she provided indicated, "Behavior Management is completed monthly with attendance from the social service director, director of nursing/designee, and pharmacy consultant. Each resident is evaluated per the MDS(minimum data set) calendar to ensure that they are evaluated quarterly. Once the behavior management team has concluded recommendations(sic) from the meeting. Steps are as follows:"</p>						

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	<p>1. The recommendations were given to the DNS by the pharmacy consultant.</p> <p>2. The recommendations were then given to the Social Service Director (SSD) for review.</p> <p>3. The SSD reviewed the recommendations and then rounds with the appropriate physician for evaluation.</p> <p>4. Once the physician had reviewed and made recommendations, they were returned to the SSD.</p> <p>5. The SSD then forwarded recommendations to the Unit Managers for follow up and order implementation.</p> <p>6. The SSD then followed up to ensure all recommendations and physician orders were completed within 72 hours.</p> <p>3.1-25(j)</p>						

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F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on interview, and record review, the facility failed to ensure 3 resident call lights were functioning correctly when checked. This deficiency affected 3 of 40 residents who were reviewed for call light function Residents #22, 29, and 75. Findings include: At 2:23 p.m., on 2/18/13, the 2 emergency call lights, 1 on the wall to the right of the toilet, and 1 on the wall by the shower stalls, in the bathroom in room 315 were tested. When the strings attached to the call lights were pulled to test for functioning, the call light indicator over the door was not lit, and did not sound. LPN #1 tested the call lights at 2:30 p.m., on 2/18/13, and verified the call lights did not function and indicated he would contact the maintenance man. The LPN indicated there were 2 residents residing in the room, and Resident #29 ambulated</p>		F0463	<p>It is the policy of this facility that all resident call lights function correctly.I. No negative outcome for residents # 22,29,75II. All other residents have the potential to be affected.III. Facility wide audit was done to check the call lights for proper function. (see attachment # 6). They were found to be working properly.Audit tool will be implemented and done on a monthly basis, and done by Maintenance Director or Designee, thru out the facility, to ensure that all call lights are working correctly. (see attachment # 6,a) They will also be documented on the electronicTELS system and this will be reviewed by the ED monthly.IV. Audit tools will be brought to the monthly QMP meetings by the Maintenance Director, for committee review, to ensure ongoing compliance, for 6 months.V. Completion Date: 3/22/2013</p>		03/10/2013	

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	<p>independently and took herself to the bathroom, and Resident #75 used the bathroom with assistance of staff. The Maintenance Director was observed in the bathroom at 2:45 p.m., on 2/18/13 fixing the call light.</p> <p>The Maintenance Director was interviewed, at 10:05 a.m. on 2/19/13, and indicated someone probably pulled the string on the call lights too hard and broke the switch which activated the call light.</p> <p>The Maintenance Director was interviewed, at 10:56 a.m., on 2/21/13, and indicated the 2 call lights in the bathroom were pigtailed in to each other, so if one was not working, the other one wouldn't work. He indicated the call light by the shower was pigtailed in, and was yanked so hard, the wire connection was broke, so neither light worked. He indicated he checked each call light on a monthly basis so checked so many call lights per week for functioning. He indicated according to his record, he had last checked the call light in room 315 on 2/4/13. He indicated the nursing staff also checked the call lights for functioning during their Interdisciplinary Team (IDT) rounds.</p>						

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	<p>The Director of Nursing Services was interviewed at 11:08 a.m., on 2/21/13, and indicated the IDT held care plan meetings with residents, they would go to the resident's room, and check the room and call lights for functioning as part of the IDT meeting.</p> <p>The IDT Assessment and Progress Notes were reviewed for Residents #29 and #75, at 3:00 p.m., on 2/21/13. Resident #29's most recent assessment was dated 12/18/12, and Resident #75's assessment was dated 2/13/13, however, even though there was a safety review section on the form, there was no documentation regarding the call lights.</p> <p>On 2/19/13 at 8:40 a.m. the call light in Resident #22's room was checked and did not function properly. The resident indicated he had to pull on the call light cord for the call light to work properly.</p> <p>On 2/21/13 at 1:45 p.m., an interview with the Maintenance Supervisor indicated the wall receptor where the call light was plugged into was bent so the call light did not function properly when the call light was turned on by the resident. The Maintenance Supervisor indicated the</p>						

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	<p>call lights are also checked when the resident has their care plan meeting.</p> <p>The Interdisciplinary Assessment and Progress Notes indicated the resident had a care plan meeting on 2/12/13.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>						

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F9999	<p>3.1-14 PERSONEL:</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date give, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is</p>		F9999	<p>It is the policy of this facility that mantoux will be given to all perspective employees before hire. I. No residents or staff were negatively affected. II. All residents could have the potential to be affected. An audit of the past 3 mos of new hires audited, by the DSD.(See attachment # 7a)III. The Director of Staff Developement will administer the mantoux at the time of the M.D.'s physical.(see attachment # 7 &7a)The mantoux will be read 48 hours prior to orientation and results documented.The second step will be scheduled for two weeks from this completion date and time.IV. The Director of staff developement will audit all new hires on a monthly basis to ensure continuity in the mantoux process.Using the Attached audit tool (see attachement # 8)The results will be brought to the monthly QMP meetings by the DSDfor reveiw by the committee for 6 mos.V.Completion date 3/22 2013</p>		03/10/2013	

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	<p>negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 4 of 5 employees (#1, 2, 3, 5) received a 2nd step Mantoux skin test for tuberculosis in a timely manner. In addition, one of 5 employee's reviewed did not have their initial Mantoux skin test read (#4) before starting employment.</p> <p>Findings include:</p> <p>Review of employee #1's record indicated they received their first step Mantoux skin test on 1/2/13 and was read on 1/5/13 and was 0mm induration. The facility failed to administer the 2nd step Mantoux skin test in a timely manner (between 1-3 weeks after the results are read for the first step).</p> <p>Review of employee #2's record indicated they received their first step Mantoux skin test on 1/25/13 and was read on 1/28/13 and was 0mm</p>						

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	<p>induration. The facility failed to administer the 2nd step Mantoux skin test (between 1-3 weeks after the results are read for the first step).</p> <p>Review of employee #3's record indicated they received their first step Mantoux skin test on 1/2/13 and was read on 1/5/13 and was 0mm induration. The facility failed to administer the 2nd step Mantoux skin test (between 1-3 weeks after the results are read for the first step).</p> <p>Review of employee #5's record indicated they received their first step Mantoux skin test on 1/9/13 and was read on 1/12/13 and was 0mm induration. The facility failed to administer the 2nd step Mantoux skin test (between 1-3 weeks after the results are read for the first step).</p> <p>Review of employee #4's record indicated they received their first step Mantoux on 2/6/13 but the record did not indicate the test had been read.</p> <p>An interview with the Director of Nursing (DN) on 2/21/13 at 2:30 P.M. indicated the 2nd step Mantoux skin tests were not administered in a timely manner for employee's 1,2,3,5. The DN indicated employee #4's initial Mantoux was not read in a</p>						

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